APPENDIX A

SAUSALITO PHARMACY, INC., et al. v. BLUE SHIELD OF CALIFORNIA, et al.

U.S. District Court, Northern District of California. No. C-78-2196-RFP. Filed May 12, 1980.

MEMORANDUM AND ORDER

PECKHAM, Chief D. J.: This is an antitrust action challenging the legality of contracts maintained by defendants in connection with prepaid prescription drug plans. Two motions for summary judgment are currently pending before the court. Plaintiffs move for summary judgment on the issue of antitrust liability. Defendant California Physicians' Service ("Blue Shield") moves for summary judgment on grounds that its agreements are exempt from the antitrust laws under the state action exemption of *Parker v. Brown* [1940-1943 TRADE CASES ¶ 56,250], 317 U. S. 341 (1943). We deny both motions.

Background

Plaintiffs are independent retail pharmacists who participate in prepaid prescription drug plans under contract with various of the defendants. Defendants are insurance companies and plan administrators who respectively underwrite and administer the prepaid prescription drug plans.

Two separate types of agreements are involved in prepaid drug plans; first, the insurance agreement between the insurer and the beneficiary; and second, the participating pharmacy agreement between the insurer and the pharmacy (or between the plan administrator and the pharmacy for those plans which are not administered by the insurer).

The terms of the insurer/beneficiary agreements vary somewhat, but all provide that the insurer will pay the

cost of prescription drugs for the beneficiaries in excess of an amount termed the "deductible" in some plans or the "co-pay amount" in others, if the beneficiary purchases the drugs pursuant to the plan at a participating pharmacy. The amount of the deductible varies from plan to plan. The plans also allow beneficiaries to purchase drugs from a non-participating pharmacy or from a participating pharmacy but not pursuant to the terms of the prepaid drug plan. In these transactions, the beneficiary purchases the drugs from the pharmacist and pays the pharmacist's ordinary price, and then the insurer reimburses the beneficiary for 75 percent of the reasonable cost of the drugs.

The participating pharmacy agreements provide that the pharmacy will charge the beneficiary no more than the deductible or co-pay amount for drugs purchased under the terms of the plan, but the pharmacy may forego this payment or discount it if it chooses. The insurer (or the administrator for some plans) will then reimburse the pharmacy for the cost of the drug, plus a fixed dispensing fee, less the deductible or co-payment. The cost of the drug is determined by reference to average wholesale prices. The dispensing fee is set in the contract between the insurer and the pharmacy and varies from one plan to the next. Typically, the dispensing fee is determined by the insurer and offered to the pharmacy on a take-it-or-leave-it basis in the participating pharmacy agreement.

Some plans are both underwritten and administered by the insurer. Others are underwritten by the insurer and administered by a separate administrator compensated by the insurer on the basis of the number of transactions administered. In the latter situation the administrator itself maintains agreements with participating pharmacies, but

for either type of plan the terms of the participating pharmacy agreement are set by the insurer.

Plaintiffs' Motion

Plaintiffs allege that the participating pharmacy agreements are price-fixing contracts which are *per se* illegal under the Sherman Act. Their main contention seems to be that the provisions in the agreements limiting the pharmacies to collecting no more than the deductible from the beneficiary fix a maximum price and as such are unlawful *per se*. Plaintiffs also contend that the agreements on their face reveal a conspiracy among defendants to fix prices, but the evidence uncovered to date does not support this charge. The precise terms of the various plans differ, and plaintiffs have failed to produce any direct evidence of a horizontal conspiracy. Thus the primary argument urged by plaintiffs in support of their motion for partial summary judgment is that the participating pharmacy agreements each separately fix prices.

[*Fixed Prices*]

Plaintiffs attempt to characterize the deductible as a price in and of itself which defendants are unlawfully fixing in their agreements with plaintiffs. We are not persuaded that this characterization correctly states the economic reality of the situation. The price of the drugs is indeed fixed by the agreements—but the deductible is not that price. The price fixed in the agreements is rather the cost of the drugs (determined by market forces as reflected in average wholesale cost) plus the dispensing fee set by the insurer. The deductible is merely the portion of that fixed price which the pharmacy may recover directly from the beneficiary. The remainder will be paid by the insurer.

The amount of the deductible is not set in the participating pharmacy agreement, but rather in the agreement between the insurer and the beneficiaries. The prohibition against charging the beneficiary more than the deductible is merely the mechanism that the insurance companies use to apply their deductibles in prepaid drug transactions. A system where the insurer pays the full price set in the insurer-/pharmacy agreement to the pharmacist and then bills the beneficiary for the amount of the deductible would have a similar economic effect, although it might be more cumbersome to administer. Furthermore, the challenged system has the virtue of allowing competition among participating pharmacies for the business of beneficiaries in that the pharmacies may discount the deductible or decline to collect it entirely. On the basis of the evidence currently before us, we think that the "price" which is "fixed" in the participating pharmacy agreements is not the amount of the deductible but rather the amount of ultimate reimbursement to the pharmacy—i. e., the wholesale cost of the drugs plus the fixed dispensing fee.

[*Inapplicability of Per Se Rule*]

All parties agree that the agreements challenged in this action are substantially similar to the agreements considered by the Supreme Court in *Group Life & Health Insurance Co. v. Royal Drug Co.* [1979-1 TRADE CASES ¶ 62,479], 440 U. S. 205 (1979). In that case the Supreme Court held that insurer/pharmacy agreements of this type are not exempt from the antitrust laws under the McCarran Ferguson Act, 15 U. S. C. §§ 1011 et seq. Section 2(b) of the Act, 15 U. S. C. § 1012(b), creates an exemption from the Sherman Act for "the business of insurance" to the extent that it is regulated by state law. In deciding that

this type of insurer/pharmacy agreement is not "the business of insurance," the Supreme Court observed that the essential feature of insurance agreements is the underwriting and spreading of risk. 440 U. S. at 211. The Court concluded that these contracts are not insurance agreements but rather "arrangements for the purchase of goods and services" by the insurer. *Id.* at 214. Thus the Supreme Court viewed the insurer as the purchaser of pharmaceuticals under this type of agreement. Plaintiffs' remonstrations to the contrary notwithstanding, we think that this characterization of the agreements was essential to the outcome of the case and is thus "holding" rather than "dicta."

Accepting, as we must, the Supreme Court's view that the insurer is the purchaser in these agreements, it is plain that the agreements are not *per se* violative of the antitrust laws. Virtually every contract for the sale of goods "fixes" the "price" at which the goods are to be sold. This is "price-fixing" only in the most trival sense of the term. Not every agreement which literally fixes a price gives rise to *per se* liability under the antitrust laws. See generally *Broadcast Music, Inc. v. Columbia Broadcasting Systems, Inc.* [1979-1 TRADE CASES ¶ 62,558], 441 U. S. 1 (1979).

Plaintiffs urge that even if the insurers are purchasers, the administrators of the plans cannot be characterized as purchasers and yet they too fix prices in their contracts with participating pharmacies. Since the plan administrators are not purchasers, plaintiffs argue that it is a *per se* violation of the antitrust laws for them to dictate a maximum price, and summary judgment is therefore appropriate as to the claims against these defendants.

We are not persuaded by this reasoning. The evidence adduced so far is undisputed that the terms of the participating pharmacy agreements are set by the insurer, whether the plan is administered by the insurer or by a separate administrator. The administrator, although not itself a purchaser, acts as agent for the purchaser. The use of an administrator to process the transactions does not itself convert what the Supreme Court has characterized as "agreements for the purchase of goods and services" into the sort of price-fixing agreements which are *per se* illegal under the Sherman Act.[1]

Our conclusion that the participating pharmacy agreements are not *per se* unlawful is fortified by the recent decision of the Ninth Circuit in *State of Arizona v. Maricopa County Medical Society* [1980-1 TRADE CASES ¶ 63,239, 1980-81 TRADE CASES ¶ 53,573], Nos. 79-3427, 79-3612, Slip Op. 2374, — F. 2d — (9th Cir., March 20, 1980). In that case the State of Arizona challenged the practice of two foundations for medical care (FMCs) and a county medical society of setting by majority vote the maximum fees that physician members may claim in full payment for health services they provide to policyholders of FMC-approved insurance plans. In upholding the district court's denial of the State's motion for summary judgment, the Ninth Circuit observed:

> In truth, we know very little about the impact of this and many other arrangements within the health care

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[1]Plaintiffs might nonetheless be able to establish *per se* liability if they can prove their allegations that the insurer defendants have conspired along with the administrator defendants to fix horizontally the terms for reimbursing pharmacies in prepaid drug transactions. We reiterate that they have not yet done so, and the material facts underlying this claim are hotly disputed.

> industry. This alone should make us reluctant to invoke a per se rule with respect to the challenged arrangement.

Slip Op. at 2378, — F. 2d at —.

Defendants correctly point out that insurer/pharmacy agreements of the type challenged here have never before been subject to antitrust scrutiny. Under the circumstances, it would be unduly precipitous to apply the *per se* rule invoked in judging practices "which because of their pernicious effect on competition and lack of redeeming virtue are conclusively presumed to be unreasonable." *Northern Pacific Railway Co. v. United States* [1958 TRADE CASES ¶ 68,961], 356 U.S. 1 (1958).

The standard for judging the legality of the participating pharmacy agreements is thus the ordinary Sherman Act standard of the rule of reason. See *Standard Oil Co. v. United States*, 221 U. S. 1 (1911). The court will require a more complete factual record in order to measure the effects of these agreements on competition under this standard. Summary judgment at this stage of the proceedings would be premature. *Poller v. Columbia Broadcasting System, Inc.* [1962 TRADE CASES ¶ 70,228], 368 U. S. 464 (1962).

Defendant Blue Shield's Motion
[State Action Immunity]

Defendant Blue Shield moves for summary judgment in its favor on grounds of state action immunity. Blue Shield asserts that it is unique among the defendants in that it is a "health care service plan" licensed and regulated by the California Department of Corporations under the Knox-Keene Health Care Service Plan Act of 1975, codified at Cal. Health & Safety Code §§ 1340 *et seq.* Blue Shield

argues that the Knox-Keene Act requires it to execute the participating pharmacy agreements and to include in the agreements the provision challenged in this lawsuit prohibiting pharmacists from charging beneficiaries more than the deductible. It therefore argues that the challenged practice is immune from the antitrust laws under the state action doctrine of *Parker v. Brown* [1940-1943 TRADE CASES ¶ 56,250], 317 U. S. 341 (1943).[2]

[*Applicability*]

Plaintiffs argue that the state action exemption is not available to private parties such as Blue Shield, citing *Cantor v. Detroit Edison Co.* [1976-1TRADE CASES ¶ 60,947], 428 U. S. 479 (1976). We disagree. Had the Supreme Court considered the state action exemption to be unavailable to private parties, it could more easily have decided the *Cantor* case on that basis than on the more intricate grounds that passive state regulatory approval of a challenged practice is insufficient to confer immunity. Indeed, in a footnote to the majority opinion in *Group Life & Health Insurance Co. v. Royal Drug Co.*, the Court observed that some agreements of this type might arguably be exempt from the antitrust laws under the state action exemption, depending on the extent of state regulation. 440 U. S. at 233 n. 41.

[*State Policy; Supervision*]

In its most recent decision on the state action exemption, the Supreme Court unanimously held that there are two standards for antitrust immunity under *Parker v. Brown*.

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[2]Blue Shield does not assert that the state action doctrine would afford it antitrust immunity from plaintiffs' charges of a horizontal agreement among defendants to fix the terms of the participating pharmacy agreements.

California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc. [1980-1 TRADE CASES ¶ 63,201], 48 U. S. L. W. 4238 (March 3, 1980). First, the challenged restraint must be clearly articulated as state policy; second, the policy must be actively supervised by the state itself. *Id.* at 4240.

Blue Shield's moving papers present substantial undisputed evidence that the first element is satisfied in this case. The Knox-Keene Act and its implementing regulations require Blue Shield to execute written contracts with providers of health care services, including pharmacies. The statute specifically allows charging a deductible or co-payment which is clearly disclosed to the beneficiary:

> Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a co-payment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that such co-payments, deductibles, or limitations are reported to, or held unobjectionable by, the Commissioner and set forth to the subscriber or enrollee pursuant to the disclosure provisions of § 1363. Cal. H. & S. § 1367(i).

Regulations promulgated under the Act require that the insurer prohibit providers from imposing a surcharge for covered services:

> *Contracts with Providers.*
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> Written contracts must be executed between the Plan and each provider of health care services which regularly furnishes services under the Plan. All contracts with providers shall be subject to the following requirements:
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> (d) The contract shall prohibit surcharges for covered services and shall provide that whenever the Plan

> receives a notice of any such surcharge it shall take appropriate action.

Cal. Admin. Code § 1300.67.8. "Surcharge" is defined as follows:

> Surcharge means an additional fee which is charged to a subscriber or enrollee for a covered service but which is not approved by the Commissioner, provided for in the plan contract and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage.

Cal. Admin. Code § 1300.45(p). Thus Blue Shield argues that it is required by state law to limit the amount that the pharmacies may charge the beneficiary to the amount of the deductible or co-payment disclosed to the beneficiary in the plan—any greater amount would be a "surcharge."

It is not yet clear, however, whether the second test for the state action exemption is satisfied. On the basis of the record before us, we are unable to determine whether the policy set forth in the above-cited provisions of state law is actively supervised by the state itself. We must therefore deny Blue Shield's motion.

Conclusion

On the basis of the foregoing memorandum,

It is Hereby Ordered that

(1) plaintiffs' motion for summary judgment be denied; and

(2) defendant Blue Shield's motion for summary judgment be denied.

APPENDIX B

SAUSALITO PHARMACY, INC., et al. v. BLUE SHIELD OF CALIFORNIA, et al.

U. S. District Court, Northern District of California. No. C-78-2196 RFP. Filed March 16, 1981.

MEMORANDUM AND ORDER

PECKHAM, D. J.: Defendants in this antitrust action have moved this court for summary judgment on the issue of their liability under Section 1 of the Sherman Act and the corresponding section of the Cartwright Act. This court, having heard oral argument on the motion on December 22, 1980 and having fully considered all matters herein, decides to grant the motion with respect to all defendants in the action. In addition, defendant Blue Shield renewed its motion for summary judgment on the grounds that its agreements are exempt from the antitrust laws under the state action exemption set forth in *Parker v. Brown* [1940-1943 TRADE CASES ¶56,250], 317 U. S. 341 (1943). As we grant the motion for summary judgment on the merits, we do not reach a decision on Blue Shield's claim of state action immunity.

I. *Background*

A. *Factual*

Plaintiffs in this antitrust action are challenging the legality of prepaid prescription drug plans administered or underwritten by the defendants. The plaintiffs are independent retail pharmacies which participate in defendants' prepaid drug plans.

The defendants—insurance companies and plan administrator companies—maintain two separate agreements for

each plan. The first agreement is between the insurance company and the insured. Although the terms vary from plan to plan, generally they provide that the insured will pay a certain deductible (or copayment) of the cost of prescription drugs and the insurer will pay the rest. The amount of the deductible varies among the defendants and among the plans maintained by each defendant as well. In order to receive the benefit of the agreement, the insured must purchase from a pharmacy which participates in the prepaid plan with the insurance company. If the insured chooses to purchase his drugs elsewhere, he must pay the entire purchase price; he is, however, generally entitled to reimbursement from the insurer. The amount of reimbursement differs from plan to plan.

The second agreement is between the pharmacy and the insurer (or the pharmacy and the plan administrator if the insurance company does not administer its own plan). Each agreement contains three price components. The first, the deductible or copayment, is collected by the pharmacy from the insured. Under the pharmacy agreement, the pharmacy may not charge the insured any more than this amount. The second component—the ingredient cost—is determined by market constraints and generally equals or exceeds the participating pharmacies' actual acquisition cost for the prescription drug from its suppliers. This amount is paid directly to the pharmacy by either the administrator or insurer. The final price component, the dispensing fee, in effect, attempts to reflect a reasonable profit for the pharmacy. This amount also varies from plan to plan and is determined by market constraints.

The pharmacy agreements are prepared by the insurance companies and are presented to the pharmacies on a take-

it-or-leave-it basis; the member pharmacies and the insurance companies do not negotiate the terms of the contract. The pharmacies are free, however, to choose among the various existing plans offered by the different insurance companies. Some insurance companies do not administer their own plans; in that case, the administrator deals directly with the pharmacy. The terms of the plan and the amounts of the price components, however, are in all cases set by the insurance companies.

B. *Procedural*

In October of 1979, plaintiffs moved for summary judgment on the grounds that the pharmacy agreements were *per se* violative of Section 1 of the Sherman Act. We deferred ruling until a decision was issued in *Group Life & Health Insurance Co. v. Royal Drug* [1979-1 TRADE CASES ¶ 62,479], 440 U. S. 205 (1979) in which the Court considered whether substantially similar insurer/pharmacy agreements were within the "business of insurance" exception to the Sherman Act and therefore exempt from scrutiny. Holding that such agreements were not within the "business of insurance" exception, the Court characterized these agreements as "arrangements for the purchase of goods and services by [the insurer]." 440 U. S. at 214. Relying on this characterization, we denied plaintiffs' motion for summary judgment, holding that contracts between a purchaser [insurance company] and seller [pharmacy] are not the sort of price fixing agreements that are *per se* illegal under the Sherman Act. We further held that such agreements were to be scrutinized under the rule of reason standard.

In the same order, we considered defendant Blue Shield's motion for summary judgment on the grounds of state action immunity. In denying this motion, we held that the second criteria in establishing immunity—the policy must be actively supervised by the state itself—was not sufficiently established. Blue Shield again moves for summary judgment on the ground of immunity by virtue of state supervision.

Plaintiffs, in their complaint, alleged several antitrust violations. They are proceeding now, however, only with respect to their claims under Section 1 of the Sherman Act (and corresponding sections of the Cartwright Act). Plaintiffs allege both vertical and horizontal violations.

II. *Discussion*

A. *Introduction*

Section 1 of the Sherman Act provides, in relevant part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.

Defendants contend that the pharmacy agreements at issue are *per se* legal under the Act. While this characterization may be somewhat inaccurate as all contracts are tested under the rule of reason for the extent of their anticompetitive effect and are therefore not *per se* legal, we assume that defendants mean that, as a matter of law, these contracts do not amount to *unreasonable* restraints of trade.

Plaintiffs continue to argue that the defendants are not purchasers of the prescription drugs in that they never take title, possession, use or any other ownership interest

in the drugs. Thus, plaintiffs again seek to characterize the customer-beneficiary as the "purchaser" of the drug. In response to this argument, we reiterate our ruling in the May 12, 1980 Memorandum and Order denying plaintiffs' motion for summary judgment: the Supreme Court's characterization in *Royal Drug, supra,* of virtually identical agreements as "arrangements for the purchase of goods and services" was not mere *dicta* but was essential to the outcome of the case, and therefore dictates the view which this court must adopt. We therefore hold that the pharmacy agreements at issue here constitute agreements between the buyers and sellers of goods. This holding applies equally to agreements between pharmacies and insurance companies and those between pharmacies and plan administrators for the reasons set forth in our prior order. (See Memorandum and Order of May 12, 1980, p. 5.)

B. *Vertical Restraints of Trade*

The thrust of plaintiffs' first charge is that the contracts vertically fix prices in two ways: (1) the agreement fixes the amount of copayment or deductible which the pharmacy may collect from the customer-beneficiary; and (2) the agreement fixes the total price which the pharmacy may collect from the insurance company at an amount other than the pharmacists' usual and customary rate. With respect to the first method of alleged price-fixing—the fixing of the deductible—we held in our prior memorandum that the "price" which is "fixed" in the participating pharmacy agreements is not the amount of the deductible but rather the amount of ultimate reimbursement to the pharmacy by the insurance company. We have no reason to diverge from that view now. As we noted in our prior order, the amount of the deductible is not set in the par-

ticipating pharmacy agreement, but rather in the agreement between the insurer and the beneficiaries. The prohibition against charging the beneficiary more than the deductible is merely the mechanism utilized by the insurance companies to apply their deductibles in prepaid drug transactions. Thus, while the price of the drugs is indeed "fixed" by the agreements, the deductible is not that price; the price "fixed" in the pharmacy agreements is the cost of the drug plus the dispensing fee. In analyzing plaintiffs' claim of vertical restraint of trade, we proceed therefore only with respect to plaintiffs' allegation that the agreement fixes the total price which the pharmacy may collect from the insurance company.[1]

It is well established that vertical agreements may be violative of the Sherman Act if they fix prices to be charged third parties. As the Third Circuit stated in *Sitkin Smelting & Refining Co. v. F. M. C.* [1978-1 TRADE CASES ¶ 62,034], 575 F. 2d 440 (3d Cir. 1978):

> The price fixing within the scope of the *per se* prohibition of section 1 is an agreement to fix prices to be charged in transactions with third parties, *not between the contracting parties themselves.*

575 F. 2d at 446. As this contract does not set prices to be charged third parties, the issue to be decided is whether

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[1]At oral argument, plaintiffs likened this scheme to one involving resale price maintenance; that is—where a wholesaler seeks to control not merely the prices at which its agent may sell its products, but also the prices for all sales by all dealers at wholesale or retail. *Dr. Miles Medical Co. v. John D. Park & Sons,* 220 U. S. 373 (1911). This court is unable to accept this analogy. The provider agreements do not control any sale other than the one between the insurance company and the pharmacy. The insurance company, as purchaser of the drugs, has in no way restricted the price at which the pharmacist may sell to third parties. Indeed, the provider agreements do not even contemplate resale.

these agreements are *unreasonable* vertical restraints of trade. Analysis of the applicable case law reveals a variety of different approaches to this question. No matter which we take, however, the conclusion that the agreements do not violate the rule of reason is inescapable.

First, it should be noted that no case has directly considered whether pharmacy agreements, like those at issue here, violate the antitrust laws. The Supreme Court in *Royal Drug* only decided that such agreements did not come within the "business of insurance" exception. The Court did take notice, however, of the position of the Antitrust Division of the Department of Justice that pharmacy agreements do not violate the Sherman Act.

[Michigan Association *Case*]

There does exist, however, significant case authority which has considered the legality of similar provider agreements under the antitrust laws. In the case most directly on point, the court granted summary judgment in favor of the insurance company. In *Blue Cross & Blue Shield v. Michigan Association of Psychotherapy Clinics*, 1980-2 TRADE CASES ¶ 63,351 (E. D. Mich. 1980), the provider agreement established that the out-patient clinics ("OPC") would furnish mental health services covered by Blue Cross plans to "any eligible member" and would look solely to Blue Cross for reimbursement in accordance with ceiling rates and policies established by Blue Cross. The agreements also provided that the reimbursement would be limited to the lesser of the provider's normal billing rate for such services or the applicable ceiling rate set by Blue Cross.

The OPCs claimed two price-fixing violations. First, they argued that the agreement fixed prices for services provided to Blue Cross members. In response to this claim, the court stated:

> While the agreements between [Blue Cross] and participating OPC's set the maximum price which [Blue Cross] will pay for covered services rendered to its members, this clearly is not a violation of anti-trust laws. [Blue Cross], as a purchaser of health care services for its members, and participating OPC's as sellers of those services, are not prohibited by anti-trust statutes from contractually fixing a sale price for the purchase of a commodity between themselves.

1980-2 TRADE CASES ¶ 63,351 at 75,794. Second, the OPCs argued that the agreements effectively set the ceiling rates that OPCs could charge nonmembers of Blue Cross. The court found as a matter of fact that no such compulsion existed.

The court in *Michigan Association* also recognized that practices which are not *per se* violative of the Sherman Act may be violative if, under the rule of reason standard, they effectively restrain commerce. In this regard, the court stated:

> However, the only antitrust violation alleged . . . is that the contracts between [Blue Cross] and the participating OPC's constituted price-fixing agreements; [*OPCs*] *assert no other effect on price formation, or other type of restraint of trade, independent of what the contract terms above require* . . . . Since the Court has determined that no compulsion [to charge non-Blue Cross rates equivalent to Blue Cross ceiling rates] exists under the terms of the contract, they are not price-fixing agreements as [the OPC's] allege and summary judgment [for the insurer] is appropriate.

Supra at 75,795. Thus, the court in *Michigan Association* has taken the position that the contract, insofar as it is merely an agreement between a purchaser and seller of services and does not fix prices outside of those agreed upon in the contract itself, does not violate the rule of reason. Similarly, in the present case, apart from the claims of horizontal conspiracy which will be discussed later, plaintiffs allege "no effect on price formation independent of what the contracts require." In listing what they consider to be disputed facts to be resolved under the rule of reason standard, plaintiffs do not enumerate any effect on price levels except that, as a result of the contract, they are unable to obtain the same profit margin as they do from "cash and carry" customers. The failure to make more money however, is simply not the kind of problem which the antitrust laws address. Quite the contrary, the primary goal of the antitrust laws is consumer welfare, not competitor welfare. *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.* [1977-1 TRADE CASES ¶ 61,255], 429 U. S. 477, 488 (1977).

In our view, under the reasoning of the court in *Michigan Association* on the issue of the vertical restraint imposed by the provider agreements, summary judgment in favor of the defendants is appropriate. Indeed, plaintiffs in the present case do not even attempt to distinguish *Michigan Association* but urge instead, without further argument, that it was wrongly decided. We cannot agree.

[Quality Auto Body *Case*]

Another approach in determining the legality of similar agreements under the rule of reason standard is found in *Quality Auto Body, Inc. v. Allstate Insurance Co.*, 1980-2 TRADE CASES ¶ 63,507 (N. D. Ill. 1980). In that case, informal

vertical arrangements existed between insurance companies and automobile body shops under which shops would follow insurance company guidelines for repair rates in exchange for being placed on lists of preferred body shops. In some circumstances, the insurance company might negotiate the price with a body shop that had indicated that it could not do the work for the price set forth in the original estimate developed by the insurance company. If agreement with the shop could not be reached, the customer could still deal with that shop but would be required to personally make up the difference between the price charged by that shop and the price listed in the insurance company guidelines.

In analyzing whether such agreements impermissibly fix prices, the court first characterized the agreement as a contract between seller and buyer, and noted that, as such, it cannot constitute a *per se* violation unless it contains restriction on one parties' activities other than those involved in the sale itself (such as resale price control). The court concluded that no such restraints were present in the agreements with the body shops. Next, the court determined that the rule of reason standard was applicable to test the legality of such agreements, recognizing that the Supreme Court in *Royal Drug* had indicated that such agreements might have anticompetitive effects. Because the Supreme Court did not set forth any tests for evaluating such effects, the court in *Quality Auto Body* developed the following guidelines:

> The question, then is whether the alleged agreements between each of the defendants and various "preferred" shops are in fact abuses of the defendants' buying power. . . . This court concludes that the plaintiff's burden of proving that the provider agreements unlawfully restrain trade would be satisfied if it could

> be shown that there exists a conspiracy between the defendants to fix prices, or a conspiracy to boycott the plaintiff's business, and *if the provider agreements are a means of implementing those conspiracies. The court also concludes that absent proof of price fixing or of a boycott, the provider agreements are nothing more than contracts between buyer and seller determining the price of services that the seller will perform, and are not illegal.*

Supra, at 76,669 (emphasis added). In *Quality Auto Body*, the court found no evidence of any unlawful combination and therefore granted summary judgment in favor of defendants, holding that, as a matter of law, the agreements did not violate the Sherman Act.

Thus, following the test set forth in *Quality Auto Body*, our determination of the legality of the vertical arrangement depends on our findings on the claim of an illegal horizontal conspiracy. As will be discussed more fully later, this court finds that no triable issue of fact exists with regard to the existence of an unlawful conspiracy or combination. Summary judgment is therefore appropriate under this theory as well.

Plaintiffs attempt to distinguish *Quality Auto Body* in two ways. First, plaintiffs argue that, unlike the present case, there were no agreements between the insurance company and the auto body shops in *Quality Auto Body*. While the agreements in that case may have been informal, the court explicitly assumed that such agreements existed for purposes of the summary judgment motion. The court stated:

> To summarize: the court assumes, for the purposes of this motion, that each of the defendants has entered

into various agreements regarding the price of auto repair with various "preferred shops."

Supra, at 76,697. Second, plaintiffs contend that *Quality Auto Body* is distinguishable because "there were individual negotiations conducted for each repair job." This is not exactly correct; as stated above, there was apparently, "in some circumstances," negotiations between Allstate and a shop if the shop could not do work for the price set forth by Allstate. Allstate, however, was not the only defendant. Moreover, while this may distinguish the case factually, we do not think it vitiates the applicability of the court's reasoning to the present case. In discussing the rule of reason standard, the court in *Quality Auto Body* did not *once* mention the possibility of independent negotiation as a factor which would point to the *reasonableness* of the defendant's conduct. Further, the court was determining the validity of an agreement between the preferred shops and the insurance company; it did not rule on the legality of defendant's conduct with shops with which it did not have an agreement. And finally, the holding and test developed by the court is sufficiently broad to nullify any effect which this difference in detail might have; that is—we think that the court's concern in *Quality Auto Body* for conspiratorial conduct overshadows the import of the possibility of individual negotiations.

[*General Rule of Reason Standard*]

A third approach involves the application of a general rule of reason standard to the present facts. In *Sitkin Smelting & Refining Co. v. F. M. C. Corp.* [1978-1 TRADE CASES ¶ 62,034], 575 F. 2d 440 (3d Cir. 1978), plaintiff sued F. M. C. alleging that defendant, pursuant to an illegal agreement, awarded the contract for purchase of scrap

metal to a lower bidder than plaintiff. Plaintiff thus argued that F. M. C. had conspired with the lower bidder (Krentzman) to fix prices. The court noted first that no *per se* violation had occurred as there was no agreement to fix the price charged to third parties. Turning to the rule of reason standard, the court stated:

> The basic principle of the rule of reason, well-articulated in *Chicago Board of Trade v. United States*, 246 U. S. 231 (1918), is that contractual restraints fall within the prohibition of § 1 only when their purpose and effect is found to have imposed an undue restraint on commerce.

575 F. 2d at 447.

Applying this standard to the present case, it is clear that the agreements were not intended to fix prices of prescription drugs for all consumers. Indeed, plaintiffs neither argue nor allege this. Moreover, as in the *Sitkin* case, the plaintiffs do not allege, and the record does not reflect, any intent to affect quantity or quality of prescription drugs or services.

This is not to say that provider agreements could never be used in a manner which restrains trade. In the Amicus Brief filed by the Department of Justice in *Royal Drug*, the government sets forth several examples of situations presenting possible illegal restraint of trade. For instance, the government considers the most troublesome opportunity for a restraint of trade to exist if the pharmacies also controlled the insurance companies. In such a scenario, the pharmacies could agree to increase prices and carry out the agreement through their control of the insurers. The government also notes that provider agreements might violate the antitrust laws if the evidence revealed that the

participating pharmacies conspired among themselves to obtain a price for distribution higher than they would otherwise obtain. Last, the government recognizes that a genuine antitrust concern would exist if it could be established that the participating pharmacies are using the pharmacy agreements to engage in predatory pricing. While this court recognizes that this list is not exhaustive of all possible arrangements which might violate the antitrust laws, it is instructive to note that none of the scenarios depicted by the government remotely resembles the facts at hand—insurance companies acting unilaterally in offering pharmacy agreements to pharmacies for their voluntary acceptance.

Regarding the effect of the agreements, plaintiffs are unable to point to any fixing of prices of prescription drugs other than the amount they collect under the contract. They do not allege that the pharmacy agreements constrain the price at which they may sell prescription drugs to "cash and carry customers" nor do they allege that the agreements affect the price structure of the prescription drug market in general. As we stated earlier, contracts between purchasers and sellers do not impermissibly restrain trade unless there is some effect on price formation other than the terms of the contract itself. See *Blue Cross & Blue Shield v. Michigan Association of Psychotherapy Clinics, supra*. Indeed, plaintiffs are unable to cite any authority suggesting that purchase and sale contracts restrain trade because the seller later decides he wants more money than he originally contracted to receive.

In conclusion, the evidence is uncontroverted that the pharmacy agreements were not entered into with the intent to control market prices, impose undue limitations on com-

petitive conditions, or unreasonably restrict competitive opportunity. In fact, as pharmacies are free to enter into provider agreements with as many insurance companies as they desire, it is quite possible that such agreements engender competition for the business of the numerous customer-beneficiaries. Moreover, plaintiffs can point to no effect of the agreements which impose an undue restraint on trade. As such, under the test developed by the court in *Sitkin*, summary judgment in favor of the defendants is appropriate.

[*Lack of Jury Issues*]

In short, plaintiffs are unable to produce any evidence which would establish an impermissible vertical restraint of trade under any existing legal theory. This court is not unmindful, however, of the strong policy against granting summary judgment in favor of the defendant in antitrust cases "where motive and intent play leading roles." *Poller v. Columbia Broadcasting System, Inc.* [1962 TRADE CASES ¶ 70,228], 368 U. S. 464 (1962). Except for the *Sitkin* approach which requires some inquiry into factors of motive and intent, plaintiffs' principal argument in the present case is that the agreement on its face evidences an illegal vertical restraint of trade. Motive and intent are, therefore, merely minor characters in this action.

Moreover, the Supreme Court has recognized that disposition of an action through summary judgment is not to be read out of antitrust cases altogether. In *First National Bank of Arizona v. Cities Services Co.* [1968 TRADE CASES ¶ 72,458], 391 U.S. 253 (1968), the Court stated:

> While we recognize the importance of preserving litigants' rights to a trial on their claims, we are not prepared to extend those rights to the point of requiring that anyone who files an antitrust complaint setting

> forth a valid cause of action be entitled to a full-dress trial *notwithstanding the absence of any significant probative evidence tending to support the complaint.*

391 U. S. at 290.

In the present action, viewing the evidence in a light most favorable to the plaintiff, this court is unable to find a genuine issue as to any material fact which would support plaintiffs' claim that the provider agreements vertically fix prices in violation of Section 1 of the Sherman Act. In their brief opposing summary judgment, plaintiffs list the following questions which they contend are triable issues of fact and preserve their right to trial on the merits on the vertical restraint theory.

> There is a disputed issue of fact as to whether defendants are purchasers of drugs from plaintiffs. There is a disputed issue of fact as to whether defendants' restraints on the transactions between the participating pharmacist and his patient constitute price-fixing in violation of Sherman Act § 1.
>
> • • •
>
> Further, plaintiffs are entitled to show the unreasonableness of defendants price-fixing restraints to a jury. The evidence presented by plaintiffs by declaration show the unreasonableness of defendants' restraints.

Plaintiffs' Opening Brief, p. 19. The first two questions listed by plaintiffs as "disputed issue[s] of fact" are clearly questions of law, the first of which was resolved in *Royal Drug* and has already been discussed in this Memorandum and Order. The second question above is, of course, the ultimate legal question to be decided in this case.

Plaintiffs' next contention is that they are entitled to a jury trial on the question of the reasonableness of the

provider agreements. Analysis of the case law reveals, however, that summary judgment is proper where there are no disputed issues of material fact, regardless of whether the relevant standard is *per se* or rule of reason. Indeed, the Ninth Circuit has recently upheld the granting of summary judgment in defendant's favor when the applicable test was the rule of reason. *Mutual Fund Investors, Inc. v. Putnam Management Co.*, [1977-1 TRADE CASES ¶ 61,445], 553 F. 2d 620 (9th Cir. 1977). See also *Quality Auto Body, Inc. v. Allstate Insurance Co.*, 1980-2 TRADE CASES ¶ 63,507 (N. D. Ill. 1980); *Blue Cross & Blue Shield v. Michigan Association of Psychotherapy Clinics*, 1980-2 TRADE CASES ¶ 63,351 (E. D. Mich. 1980). Moreover, the several factors which plaintiffs enumerate to show the unreasonableness of the provider agreements merely establish that plaintiffs do not realize as much profit under the pharmacy agreements as they do from sales to "cash and carry customers."[2] As we have stated before, the failure to make

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[2]Plaintiffs list the following several factors as establishing the unreasonableness of "defendants' restraints":

"a. That the average gross margin of a prescription sale in California is $4.85, far more than the highest dispensing fees offered in defendants' plans. . . .

"b. That despite the lower gross margins for sales to patients covered by defendants' plans, pharmacists provide substantially identical services to both cash and carry patients and prepaid patients. These additional personal services provided by pharmacists range from individual consultation to delivery of prescriptions and other services. . . .

"c. That plaintiffs compete on the basis of individualized service to their patients and that the substantially diminished profitability of sales to prepaid patients will lead to the termination of such service. . . .

more money, without more, simply does not state a claim under the antitrust laws. As the Third Circuit recognized in *Sitkin Smelting & Refining Co. v. F. M. C. Corp., supra*, the Sherman Act is not a panacea for all commercial activity which appears to some party to be unfair or unjust.

On the basis of the arguments and affidavits submitted by the parties to this action, this court concludes that no triable issue of fact exists which, under an acceptable interpretation of Section 1 of both the Sherman Act and Cartwright Act, would support plaintiffs' claim for relief. We thus grant summary judgment in favor of defendants on plaintiffs' claim that the participating pharmacy agreements impose an impermissible vertical restraint of trade.[3]

"d. That the artificially low dispensing fees fixed by defendants cause the plaintiffs to charge their cash and carry patients more than would be the case if defendants did not fix fees. . . .

"e. That as a result of defendants' price-fixing, cash and carry patients must subsidize the prepaid patients. . . .

"f. That defendants have alternative to their price-fixing scheme in the form of a usual and customary fee reimbursement system and they have the capacity to administer such a system. . . ."

To the extent that plaintiffs claim to be forced to charge cash and carry customers more in order to obtain a certain overall profit, we note that that is a business decision to be made by plaintiffs upon their entering into a contract with defendants. As such, it does not establish a price fixed for third parties by defendants nor can it be said to be an unreasonable effect on defendants' conduct.

[3]Several recent cases, either through *dicta* or express holding, support the result reached by this court on the issue of vertical restraint of trade. See e.g., *Webster County Memorial Hospital v. United Mine Workers* [1976-1 TRADE CASES ¶ 60,896], 536 F. 2d 419 (D. C. Cir. 1976); *Arkansas Pharmacist Association v. Harris*, No. 79-1592, Slip Op. (8th Cir., Aug. 13, 1980); *Proctor v. State Farm Mutual Automobile Insurance Co.* [1980-81 TRADE CASES ¶ 63,591], No. 249-72, Slip. Op. (D. D. C., Oct. 23, 1980).

C. *Horizontal Conspiracy*

The evidence is undisputed that the insurance companies and the plan administrators did not agree to a particular set of prices in the provider agreements. Each defendant has submitted affidavits to that effect and plaintiffs do not dispute their credibility or veracity.[4] Indeed, plaintiffs have abandoned their argument that defendants explicitly agreed to fix prices in the pharmacy agreements and urge instead two novel theories which, they contend, support a finding of an illegal implied conspiracy.

1. *Analysis of the agreements on their face.* Plaintiffs argue that the agreements on their face evidence an implied combination in violation of the Sherman Act. To some extent, we ruled against this theory in our prior order. There we stated:

> Plaintiffs also contend that the agreements on their face reveal a conspiracy among defendants to fix prices, but the evidence uncovered to date does not support this charge. The precise terms of the various plans differ, and plaintiffs have failed to produce any evidence of a horizontal conspiracy.

Memorandum and Order, May 12, 1980, p [1980-81 TRADE CASES ¶ 63,695]. Nevertheless, plaintiffs reiterate the charge that the pervasiveness of the scheme fixing a maximum dispensing fee and maximum deductible evidences a conspiracy. In support of their argument, plaintiffs cite two cases

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[4]Although this court is normally hesitant to grant summary judgment for defendants on the claim of an express conspiracy even when the plaintiff lacks significant probative evidence of an express agreement, in the present case, as plaintiffs have abandoned their argument of an express agreement and as the pharmacy agreements do vary significantly, the court does not feel so constrained.

which are either irrelevant or distinguishable from the present case.

Plaintiffs first cite *Matter of Cement Institute*, 37 F. T. C. 87 (1943), vacated *sub nom. Aetna Portland Cement v. F. T. C.* [1946-1947 TRADE CASES ¶ 57,490], 157 F. 2d 533 (7th Cir. 1946), reinstated *sub nom. F. T. C. v. Cement Institute* [1948-1949 TRADE CASES ¶ 62,237], 333 U. S. 683 (1948) in which the plaintiff charged that the 74 cement manufacturers, wholesalers and distributors hindered and restrained competition through a mutual understanding to employ a multiple base point system of pricing. This system, it was alleged, resulted in the quotation of identical terms of sale and identical prices for cement by the 74 corporations regardless of their location in the United States.

Contrary to the plaintiffs' characterization, *Cement Institute* did not involve an inference of conspiracy merely because of a similarity in the structure of a contract. In *Cement Institute*, the 74 corporations belonging to the Cement Institute "always and at all times (for such has been substantially the case . . .) charge[d] for their cement, precisely, to the fractional part of the penny, the price their competitors charged." 333 U. S. at 716. Moreover, the FTC made detailed findings of collective activities carried on by the Cement Institute, the industry's unincorporated trade association, such as boycotts, discharge of uncooperative employees, organized opposition to erection of new cement plants, etc. Thus, the footnote comment that:

> It is enough to warrant a finding of a combination in violation of the Sherman Act if there is evidence that persons, with knowledge that concerted action

> was contemplated and invited, give adherence to and participate in a scheme [333 U. S. at 716, n. 17]

was set in an exceedingly more egregious factual setting and provides no authority for implying a combination here. In the present action there is no evidence that any concerted action was contemplated, much less that defendants participated in some scheme with knowledge of the concerted action.

The second authority—*Catalano Inc. v. Target Sales Inc.* [1980-2 TRADE CASES ¶ 63,352], 100 S. Ct. 1925 (1980)—is irrelevant to the case at hand. In *Catalano*, beer wholesalers agreed to fix credit terms. The Supreme Court held that such an agreement could be *per se* illegal even though it merely had an indirect impact on price. *Catalano* did not involve any question of an implication of an illegal conspiracy.

Moreover, the general rule in the Ninth Circuit is that proof of analogous business conduct does not support an inference of conspiracy by itself. Such an inference is appropriate only where the actions taken are in apparent contradiction to the party's economic self-interest or where there are circumstances which logically suggest joint agreement, as distinguished from independent action. *Tripper Corp. v. Chrysler Corp.* [1980-2 TRADE CASES ¶ 63,366], 484 F. Supp. 507 (N. D. Cal. 1980); *Independent Iron Works, Inc. v. U. S. Steel Corp.* [1963 TRADE CASES ¶ 70,848], 322 F. 2d 656, 661 (9th Cir.), cert. denied, 375 U. S. 922 (1963). Plaintiffs here do not even attempt to show that it is against the economic self-interest of the insurance companies to maintain such agreements. In the absence of any such evidence, we could not make such a finding. In fact, the Supreme Court in *Royal Drug* assumed the contrary:

> By agreeing with pharmacies on the maximum prices it will pay for drugs, [the insurer] effectively reduces the total amount it must pay to its policyholders. The Agreements thus enable [the insurer] to minimize costs and maximize profits. Such cost-saving arrangements may well be sound business practice . . . .

440 U. S. at 214.

And perhaps most importantly for purposes of this question, the price terms of all plans differ, even though the structure of the agreements—(deductible, ingredient cost and dispensing fee)—remains the same. Even if the insurance companies did communicate on the question of the structure of the contract, there would be no inference of a conspiracy to fix prices. This argument—that the agreements themselves evidence an unlawful combination—must fail.

2. *Joint agency theory.* Plaintiffs contend that this theory operates in two ways to establish the existence of an unlawful conspiracy. First, plaintiffs allege that defendants Pharmaceutical Card Systems and Paid Prescriptions, as joint agents of the insurance companies, pass on information concerning insurers' dispensing fees to other insurers. This passing of dispensing fee information, plaintiffs contend, constitutes a horizontal conspiracy in violation of the antitrust laws.

[*Price Information Sharing*]

In response to this contention, it should first be noted that the only evidence which plaintiffs offer to support this allegation is the deposition testimony of Glenn Spaulding, a former employee of Paid Prescriptions, that he communicated the level of dispensing fees to the Boeing Corpora-

tion on one occasion and on another to Blue Cross of Northern California. At the same time, Mr. Spaulding also testified that, to his knowledge, Paid Prescriptions had never advised an insurer as to what the amount of dispensing fee should be, and that Paid Prescriptions had never played any role whatsoever in the determination of the dispensing fee. Thus, unlike the picture plaintiffs attempt to paint, there does not exist a large tangled web of secret passing of price information among the defendants. According to Mr. Spaulding, only on one occasion was price information passed on to a defendant in this action.

Second, the mere passing of price information, without more, does not create an inference of a horizontal conspiracy nor does it state a claim for violation of the Sherman Act. See *Kline v. Coldwell, Banker & Co.* [1974-2 Trade Cases ¶ 75,436], 508 F. 2d 226, 232 (9th Cir. 1974), cert. denied, 421 U. S. 963 (1975) (the printing of a price schedule by the Los Angeles Realty Board and its distribution to members, without more, does not establish a horizontal conspiracy in violation of the Sherman Act); *Hanson v. Shell Oil Co.* [1976-2 Trade Cases ¶ 61,052], 541 F. 2d 1352 (9th Cir. 1976), cert. denied, 429 U. S. 1074 (1977) (supplier may suggest retail price to its dealers and use "persuasion" to get them to adopt such suggested prices, and no antitrust violation can be made out unless plaintiff can show that supplier's conduct rose to the level of coercion).

Third, the case cited by plaintiffs in support of their argument simply cannot be stretched to cover the present factual situation. In *Virginia Excelsior Mills, Inc. v. Federal Trade Commission* [1958 Trade Cases ¶ 69,066], 256 F. 2d 538 (4th Cir. 1958), several competing companies

formed a new company and expressly agreed that the new company would purchase the competing companies' products, set prices for those products, and allocate market share. Contrary to plaintiffs' characterization, the court in Virginia did not state that the passing of price information constituted a *per se* violation of the antitrust laws; the court did state that:

> [T]he obligatory delegation of all discretion in fixing prices to the [newly-formed company] was a violation, *per se*, of § 1 of the Sherman Act. The primary purpose of the arrangement was to eliminate competition among the producers.

256 F. 2d at 540.

It is readily apparent that the factual situation in Virginia was considerably more onerous than the mere passing of price information to one insurance company defendant by one plan administrator defendant. Thus, even assuming the truth of this allegation, the uncontroverted statements by each defendant that the prices were set independently *plus* the dramatic difference in prices among the plans, counteract any inference of unlawful conspiracy that might arise from Mr. Spaulding's deposition testimony. In addition, this court has no reason to conclude but that the defendants in this action vigorously compete with each other for the business of the member pharmacies and the insureds.

[*Concerted Use of Market Power*]

The second joint agency theory advanced by plaintiffs is that the insurance companies, insureds and administrators use their collective market power to reduce price competition in the field of retail prescription drugs. Under normal free market conditions, plaintiffs contend, individ-

ual insureds would purchase drugs from pharmacists at prevailing market prices. Once a combination of insureds, insurers and administrators occurs, the price of drugs in the free market is driven down and the independent retail pharmacist suffers. It seems that plaintiffs are arguing that any insurance agreement which reimburses pharmacies at anything other than their usual and customary fee violates the antitrust laws. Exactly how this is so remains a mystery to this court. The only case cited by plaintiffs is clearly distinguishable. In *Matter of Atlas Supply Company*, 48 F. T. C. 53 (1951), five oil companies jointly used an agent to purchase auto accessories for their service stations, thereby coercing artificially low prices, as well as kickbacks and rebates from sellers. Plaintiffs argue that the two cases are identical: "Here the insurance companies and administrators manipulate the collective buying power of their insureds to coerce pharmacists into selling prescription drugs at prices below their usual and customary prices." However, the facts of the case without further explication, reveal the difference. In *Matter of Atlas* there was a concerted effort to coerce low prices; in the present case, there was no such collaboration.

3. *Conclusion.* It is undisputed that plaintiffs possess no direct evidence of conspiracy. Further, they have been unable to put forth a viable theory which would support their claim of an implied conspiracy. The rule in the Ninth Circuit requires the plaintiff, once the defendant has rebutted the allegations of conspiracy by probative evidence, to come forward with specific factual support of its allegations of conspiracy. *ALW, Inc. v. United Airlines Inc.* [1975-1 TRADE CASES ¶ 60,138),510 F. 2d 52, 55 (9th Cir. 1975). If the plaintiff fails to meet this burden, sum-

mary judgment for the defendant becomes proper. To hold otherwise, the Ninth Circuit stated in *Mutual Investors v. Putnam Management Co., supra*:

> would give free rein to any plaintiff who can draft an antitrust complaint capable of withstanding a motion to dismiss to go to trial with only a wing and a prayer supporting his well drafted complaint.

553 F. 2d at 624. After reviewing all arguments and evidence submitted by plaintiffs supporting their claim of horizonal conspiracy, this court concludes that summary judgment is appropriate: plaintiffs' version of the facts does not support a viable legal theory which, if accepted, would entitle them to judgment as a matter of law. *Bushie v. Stenocord Corp.* [1972 TRADE CASES ¶ 73,896], 460 F. 2d 116, 119 (9th Cir. 1972). We are convinced that plaintiffs have no more than a prayer, much less a wing, to support the allegations in the complaint.

Therefore, it is hereby Ordered that defendants' motions for summary judgment on the merits be granted.

APPENDIX C

Sausalito Pharmacy, Inc.,
Plaintiff-Appellant,

vs.

Blue Shield of California, Travelers Insurance Co., Metropolitan Life Insurance Co., et al., Defendants-Appellees.

No. 81-4198.

United States Court of Appeals,
Ninth Circuit.

Argued and Submitted March 11, 1982.

Decided May 10, 1982.

Before HAYNSWORTH*, Senior Circuit Judge, and CHOY and SCHROEDER, Circuit Judges.

PER CURIAM

In the district court, summary judgment went against Sausalito and other pharmacies complaining of prepaid prescription plans of health care insurers and administrators. The defendants had entered into contractual arrangements with participating pharmacies under which each participating pharmacy would provide prescription drugs at stipulated prices, which were alleged to be generally less than current charges of the pharmacies to uninsured customers. The claim was that such plans violated § 1 of the Sherman Act, 15 U.S.C.A. § 1, and the corresponding provision of the California Cartwright Act.

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*The Honorable Clement F. Haynsworth, Jr., Senior United States Circuit Judge for the Fourth Circuit, sitting by designation.

We agree with the district court than no viable antitrust claim was stated and affirm the judgment of the district court for the reasons stated in its opinion. *Sausalito Pharmacy Inc. v. Blue Shield of California*, 1981—1 Trade Cas. (CCH) ¶ 63,885 (N.D.Cal., March 16, 1981). *See also Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut*, 518 F.Supp. 1100 (D.Conn.1981), *aff'd*, 675 F.2d 502 (2d Cir. 1982).

APPENDIX D

In the United States Court of Appeals
For the Ninth Circuit

No. 81-4198

Sausalito Pharmacy, Inc.,
Plaintiff-Appellant,

vs.

Blue Shield of California, Travelers Insurance Co.,
Metropolitan Life Insurance Co.,
d/b/a Medimet, Aetna Life Insurance Co.,
Health Systems Institute, Paid Prescriptions, Inc.,
a Nevada Corporation,
Paid Prescriptions Inc., a New Jersey Corporation,
Pharmaceutical Card Systems,
Pre-paid Prescription Plans, Inc.
and U.S. Administrators, Inc.,
Defendants-Appellants

On Appeal from the United States District Court
for the Northern District of California

PETITION FOR REHEARING
PURSUANT TO F.R.A.P. 40

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I.

STATEMENT OF COUNSEL

Appellant petitions this Court for a rehearing of its decision affirming *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 1981-1 Trade Cas. (CCH) ¶ 63,885 (N.D. Cal., March 16, 1981). In counsel's judgment, rehearing must be granted because a material and controlling question of law (whether a *per se* or rule of reason analysis will be applied to this case once the Supreme Court rules in *Maricopa County*) has been overlooked in the decision, and because a change in the law which occurred after the case was submitted (the Second Circuit's analysis in *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, infra*) appears to have been overlooked by the panel.

II.

ARGUMENT

A. The Panel has apparently overlooked the Supreme Court's Grant of Certiorari in *State of Arizona v. Maricopa County Medical Society*

The panel's *per curiam* opinion does not cite *State of Arizona v. Maricopa County Medical Society*, 643 F.2d 553 (9th Cir. 1980), *cert. granted*, 450 U.S. 979 (1981), despite the fact that the Court's opinion in that case established the legal standard by which the instant case has been judged. *Maricopa County*, brought by the State of Arizona as *parens patriae*, challenged, under Section 1 of the Sherman Act, 15 U.S.C. § 1, the establishment and use of agreed-upon fee schedules set by physicians' associations.

The State had moved for summary judgment on the ground that the defendants' price-fixing activities constituted a *per se* violation of Section 1.

The district court denied the motion. *State of Arizona v. Maricopa County Medical Society*, 1979-1 Trade Cas. (CCH) ¶ 62,694 (D. Ariz., June 5, 1979). A dividend panel of this Court affirmed, with Judges Sneed and Kennedy writing individual opinions and Senior Judge Larson filing a vigorous dissent.[1] 643 F.2d 553 (9th Cir. 1980). The Supreme Court granted certiorari on March 9, 1981, 450 U.S. 979, and heard oral argument on November 4, 1981. Unless the Supreme Court requires further argument or briefing, a decision will be handed down before the Court adjourns in approximately six weeks.

The *Maricopa County* decision was relied upon by Judge Peckham in determining that the rule of reason, rather than a *per se* standard, would govern the instant case. This reliance was expressed in his first opinion denying plaintiffs' motion for summary judgment, *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 1980-81 Trade Cas. (CCH) ¶ 63,695 at 77,724 (N.D. Cal., May 12, 1980) and implied in his grant of summary judgment to defendants the next year. *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 1981-1 Trade Cas. (CCH) ¶ 63,885 (N.D. Cal., March 16, 1981). In its opening brief, appellant called to the Court's attention the Supreme Court's grant of certiorari in the *Maricopa County* case, and noted that a

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[1]Judge Larson found nothing peculiar in the health care industry that would justify the application of a more lenient legal standard to defendants' conduct, and rejected Judge Sneed's rationale that the reasonableness of the fee was a defense to a price-fixing charge. 643 F.2d at 563-69.

reversal of the Court's decision would dramatically alter the legal standard governing the instant case. (Opening Brief for Appellant at 23 and footnote). The same point was raised on oral argument before this Court. Yet the panel's decision fails to mention the *Maricopa County* case. By doing so, the Court is apparently reaffirming the reasoning of *Maricopa County sub silentio*, despite the possibility that the Supreme Court may overrule that decision within a matter of weeks.

If the Supreme Court does overturn the Court's decision in *Maricopa County*, the legal basis relied upon by Judge Peckham will no longer be valid. Further, a Supreme Court decision adopting a different standard would require a fresh analysis of the facts under the new rule.

Therefore, the panel's decision in the instant appeal, rendered before the Supreme Court delivers its opinion in *Maricopa County*, is premature. As the Supreme Court's decision will be announced after the time in which appellant may request rehearing has passed, appellant will have no recourse but to file a petition for certiorari if *Maricopa County* is decided favorably to appellant's position. To spare appellant this burden, Sausalito Pharmacy respectfully requests this Court to reconsider rendering an opinion before *Maricopa County* is decided.

B. The Panel apparently overlooked the Second Circuit's analysis in *Medical Arts Pharmacy of Stamford v. Blue Cross & Blue Shield of Connecticut*

The Second Circuit's decision in *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut*, ... F.2d ....., 1982-1 Trade Cas. (CCH) ¶ 64,673 (2d Cir., April 1, 1982) was rendered after oral argument in

the instant appeal, and thus neither party had the opportunity to brief or argue the points raised in that opinion. The panel's opinion in the instant case cites with approval the lower court's opinion in *Medical Arts*, but does not rely on the Second Circuit's analysis. In fact, the Second Circuit's opinion reveals a number of differences between the evidence offered by the Stamford Pharmacy, and that presented in the instant case. While the Second Circuit affirmed the lower court's decision, its analysis supports appellant's position here. Thus, rehearing is necessary in order to harmonize the Ninth Circuit's opinion in the instant case with the Second Circuit's analysis in *Medical Arts* and in order to avoid a future conflict with the Second Circuit.

In *Medical Arts*, the Second Circuit affirmed the lower Court's ruling that the participating pharmacy agreements there in question did not constitute a *per se* violation of Section 1 of the Sherman Act. The District Court had relied heavily on Judge Peckham's opinion in the instant case, agreeing with his interpretation of *Group Life & Health Ins. v. Royal Drug Co.*, 440 U.S. 205, 214 (1979) ("The Pharmacy Agreements . . . are merely arrangements for the purchase of goods and services by Blue Shield.") *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut*, 518 F. Supp. 1100, 1105 (D. Conn. 1981). The District Court also agreed with Judge Sneed's analysis in *State of Arizona v. Maricopa County Medical Society, supra*, 643 F.2d at 556, finding that the health care industry requires special consideration in Sherman Act cases.[2]

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[2]The District Court recognized, however, that the Supreme Court's grant of certiorari in the *Maricopa County* case might resolve the issue of whether such agreements should be analyzed as

The Second Circuit, while affirming the District Court, took a more expansive view of the problem. Although the District Court specifically found that the defendant insurance companies were the purchasers, 518 F. Supp. at 1109, citing *Royal Drug*, the Second Circuit held that the pharmacy agreements were "*sui generis*." The Second Circuit described the agreements as fixing prices "not precisely between seller and purchaser (but between seller and indemnitor) . . ." *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut*, ... F.2d ....., 1982-1 Trade Cas. (CCH) ¶ 64,673 at 73,662 (2d Cir., April 1, 1982).

The Second Circuit was careful to note that Medical Arts Pharmacy (unlike the appellant presently before this Court) had "'placed all [its] eggs in the *per se* basket.'" *Id.* at 73,663. The Second Circuit criticized the appellant for failing to allege that "the prices Blue Cross pays to participating pharmacies in any way affect the prices those pharmacies charge for prescription drugs provided to non-Blue Cross customers. . . ." *Id.* The Second Circuit also pointed out that no evidence had been presented in support of appellant's claims of horizontal conspiracy. *Id.* The Second Circuit's opinion thus implies that if such claims had been made, a different result might have been achieved.[8]

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per se violations, or under the rule of reason. 518 F. Supp. at 1106-07 n.8. Thus, the Supreme Court's decision in *Maricopa County* may adversely affect the continued validity of the *Medical Arts* case, as well.

[8]*Cf. Royal Drug Co. v. Group Life & Health Ins. Co.*, 556 F.2d 1375, 1381-84 (5th Cir. 1977), *aff'd*, 440 U.S. 205 (1979), in which the Fifth Circuit was sharply critical of the price-fixing practices of Blue Shield in contracts with participating pharmacies. After the *Royal Drug case* is re-tried, it is likely to be appealed again. Thus eventual conflict between the Ninth and Fifth Circuits is possible if the panel's *per curiam* opinion in the instant appeal is allowed to stand.

Such claims were made in the instant case. The evidence supporting the allegations of horizontal conspiracy is described in appellant's briefs, and need not be reargued here. In addition, appellants presented uncontroverted evidence in the form of pharmacist affidavits that

> "[t]he diminished profitability resulting from sales to persons covered by defendant's plans requires that [the pharmacist's] usual and customary fee to the cash and carry public for any given prescription be made higher to compensate for that loss of profit . . . . [This] results in the cash and carry public having to subsidize the artificially low prescription prices fixed by defendants for transactions between the pharmacist and the patient covered by defendants' plan." *E.g.*, Affidavit of Martin Sch[illegible]r, CR 900-01.

Given the Second Circuit's differing interpretation of *Royal Drug*, and its inference that the decision could have gone the other way had there been evidence of price discrimination against cash and carry customers, the panel's citation to the Second Circuit's opinion without discussion or analysis is confusing. If the panel agrees with the Second Circuit in these particulars, it should say so. If it does not, the points of divergence should be articulated so that the conflict can be identified and debated in a future appeal of this or other similar cases pending in other circuits. A question of this complexity and national importance deserves an analysis of the factors raised in the Second Circuit's opinion, which have apparently been overlooked by the panel's decision in the instant case.

III.

CONCLUSION

Prior to the Supreme Court's ruling in *State of Arizona v. Maricopa County Medical Society*, which may change the law which governed the District Court's decision, final judgment should not be entered in the instant appeal. The panel's opinion has apparently overlooked the eventuality that the Supreme Court's decision may require this case to be analyzed under the *per se*, rather than the rule of reason, standard. Thus, no final judgment should be entered until the Supreme Court acts, and rehearing must be granted if the Court overrules the Ninth Circuit in *Maricopa County*.

Furthermore, rehearing should be granted in order to analyze the issues raised in the Second Circuit's opinion in *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut*, as that opinion, announced after oral argument in this appeal, analyzes the case and the issues in a way that conflicts with the approach taken by Judge Peckham below.

For the foregoing reasons, appellant respectfully requests that rehearing be granted.

Dated: May 24, 1982.

Reuben J. Becker

Richard J. Archer
Jane Elizabeth Lovell
Archer Rosenak & Hanson

By: RICHARD J. ARCHER

Richard J. Archer
Attorneys for Plaintiff-Appellant

APPENDIX E

United States Court of Appeals
for the Ninth Circuit

No. 81-4198

Sausalito Pharmacy, Inc.,
Plaintiff-Appellant,

vs.

Blue Shield of California, Travelers Insurance Co.,
Metropolitan Life Insurance Co., et al.,

[Filed June 21, 1982]

ORDER

Before HAYNSWORTH*, Senior Circuit Judge, CHOY and SCHROEDER, Circuit Judges.

The panel as constituted in the above case has voted to deny the petition for rehearing. The petition for rehearing is denied.

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*The Honorable Clement F. Haynsworth, Jr., Senior United States Circuit Judge for the Fourth Circuit, sitting by designation.